Ansardi (HB 2083) **Act No. 401**

Prior law required every health maintenance organization (HMO) to establish procedures for utilization review. Relieved any person who participated in a utilization review by a peer review committee from any monetary or civil liability absent malice. Provided that peer review committees were not be subject to discovery and that no person was to be required to testify as to what transpired at such a review. Further required that the utilization review requirements of an HMO not fall below the appropriate standard of care and not impinge upon the independent medical judgment of the treating health care provider. Provided that prior law not be construed to prevent an HMO from conducting a utilization review program.

New law provides that HMOs shall assure full compliance with new law in establishing procedures for medical necessity reviews. Retains requirement that the medical necessity review requirements of an HMO shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider. Provides that new law shall not be construed to prevent an HMO from conducting a medical necessity review program.

Prior law required any entity operating a managed care plan to approve or disapprove an authorization for medical diagnostic testing or treatment requested from a health care provider that was of an urgent need within two working days of obtaining sufficient information or an authorization for elective care within five working days. Provided that failure to so timely approve or disapprove the request by the managed care entity constituted an authorization under the plan for the requested testing or treatment. Further authorized the commissioner of insurance, with the consent of the Dept. of Health and Hospitals (DHH), to issue necessary rules relative to utilization review; specified that accreditation by a nationally recognized accrediting body or entity recognized by the commissioner would be evidence of meeting the requirements of prior law.

New law provides that no health insurance issuer shall determine medical necessity or make other similar medical determinations unless authorized as a medical necessity review organization (MNRO) by the commissioner of insurance. Provides that no entity acting on behalf of or as an agent of a health insurance issuer and no entity other than a health insurance issuer shall make such medical necessity determinations unless licensed as an MNRO by the commissioner. Exempts MNROs from present law requiring certification by DHH as private review agents performing utilization review.

New law establishes separate procedures for authorization as an MNRO and for licensure of other entities as an MNRO, including information to be submitted to the commissioner. Provides for two-year licenses and requires renewal. Provides that the initial licensure fee and the renewal fee shall each be $1,500.

New law provides relative to the scope and content of an MNRO's medical necessity determination process, including the following requirements:

(1) An MNRO shall have a licensed physician as its medical director, who shall administer the program and oversee all review decisions.

(2) All adverse determinations shall only be made by a licensed physician or clinical peer, and any adverse determination made by an MNRO in a second level review shall only become final when a clinical peer has evaluated and concurred with such determination.

(3) Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight.

(4) Compensation to persons participating in a medical necessity determination program shall not contain direct or indirect incentives for those persons to make inappropriate review determinations.

New law establishes procedures for MNROs in making determinations of the medical necessity of an admission, procedure, or service, including setting time frames within which an MNRO may make initial, concurrent, and retrospective review determinations. Also provides for time frames and procedures for timely notifying health care providers of these determinations. Requires a written notification of any adverse determination and specifies the content of such notification. Authorizes health care providers to request reconsideration of any adverse determination; however, if the process does not resolve the differences of opinion, provides that the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Provides that such reconsideration shall not be a prerequisite to an appeal of an adverse determination.

New law provides for a standard internal appeal (first level internal appeal) of adverse determinations as follows:

(1) Written appeal procedures shall be made available to the covered person and his health care provider.

(2) A review panel shall be provided for each appeal that includes health care professionals with appropriate expertise. Additionally, concurrence by a licensed physician shall be required to make an adverse determination.

(3) The MNRO shall notify both the covered person and his provider of its decision in writing. Specifies what information the written decision shall contain, including: the title and qualifying credentials of the physician affirming the adverse determination; an explanation of the decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position; and, if applicable, a description of the process to obtain a second level review of the decision.

New law requires MNROs to establish a second level review process to give persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. Requires MNROs to provide covered persons with adequate notice of this option. Provides that a majority of any second level review panel used for an appeal shall be persons not previously involved in the appeal. Requires that appeals shall be evaluated by an appropriate clinical peer in the same or a similar speciality as would manage the case being reviewed. Provides that the review panel shall have the legal authority to bind the MNRO and the health benefit plan to the panel's decision. Establishes specific procedures for second level reviews, including the following:

(1) Holding the review meeting during regular business hours at a location reasonably accessible to the covered person or where a face-to-face meeting is not practical for geographic reasons, offering the covered person the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology.

(2) Upon request, providing the covered person with all relevant information that is not confidential or privileged.

(3) Giving the covered person certain rights, including the right to present his case to the review panel, submit supporting material both before and at the review meeting, and ask questions of any representative of the MNRO.

(4) Requiring concurrence by a clinical peer in order to make an adverse determination.

(5) Issuing a written decision, including the title and qualifying credentials of the clinical peer affirming an adverse determination of the reviewers and the rationale for the review panel's decision, to the covered person within five working days of completing the review meeting.

New law provides that a covered person may, with the concurrence of his treating health care provider, request an external review of a second level adverse determination. However, provides that an MNRO shall not be required to grant a request for an external review by the MNRO's independent review organization (IRO) until the internal appeal process has been exhausted, unless the covered person has an emergency condition or the MNRO waives the requirements for such appeal or appeals. Establishes procedures for such external review including a requirement that the IRO review all of the information and documents received and any other information submitted in writing by the covered person or his health care provider. Requires the IRO to provide notice of its recommendation to the MNRO, the covered person, and the covered person's health care provider.

New law also provides for an expedited appeal process and an expedited external review process when the time frame of a standard appeal would seriously jeopardize the life or health of a covered person or jeopardize his ability to regain maximum function.

New law provides that coverage for services required by new law shall be provided subject to terms applicable to benefits under a health plan and shall not be construed to require the plan to pay for services not otherwise covered or required. Provides that an external review decision shall be binding on the MNRO and the health insurance issuer or health benefit plan utilizing the MNRO.

New law provides that a covered person shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to new law if bad faith, negligence, gross negligence, or intentional misrepresentation was involved.

New law establishes minimum qualifications for IROs and their clinical peer reviewers, including a prohibition against their having any material, professional, familial, or financial interest with the MNRO or the covered person's health care provider.

New law requires MNROs to maintain a register of all requests for external review for which an external review was conducted during a calendar year, to be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year. Also requires MNROs to submit an annual report to the commissioner on external reviews undertaken for each health insurance issuer and health benefit plan.

New law prohibits a MNRO from disapproving emergency services necessary to screen and stabilize a covered person, requiring prior authorization of such services, or requiring that care be provided by a contracting provider in certain emergency situations. Further provides that if emergency services are authorized by a participating provider or other authorized representative of the issuer or plan, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment unless based on a material omission or misrepresentation.

New law requires a MNRO to annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

New law authorizes the commissioner of insurance to promulgate necessary rules and regulations to implement new law. Further requires the commissioner to examine a MNRO at least once every three years and authorizes him to assess health insurance issuers and licensed MNROs for the cost of performing such examinations.

New law provides for the commissioner, after notice and hearing pursuant to the provisions of Chapter 13-B, Title 49, Division of Administrative Law, to issue cease and desist orders, assess fines, or revoke or suspend a MNRO license or the certificate of authority of a health insurance issuer authorized to act as a MNRO. Specifies that failure to comply with an IRO determination within 60 days shall result in suspension or revocation of a MNRO license or a certificate of authority or assessment of a $5,000 fine per violation, up to an aggregate of $25,000.

New law provides that it shall not apply to health insurance issuers until January 1, 2001, but requires such issuers making medical determinations to file all required documentation for authorization as a MNRO with the commissioner of insurance no later than June 30, 2000.

Effective January 1, 2000.

(Amends R.S. 22:2021; Adds R.S. 22:3070-3092)